Minutes
Care Management Work Group
January 26, 2007

Next Meeting: February 16, 9 – 11 A.M. Basement Conference Room Weeks Building, Waterbury Office Complex.

Persons Present:
Peter Thomashow, CVMC; Richard Lanza, LCMH; Nick Emlen,VT Council; Tom Simpatico, VSH/UVM/FAHC; Pat Frowley, VCIN; Stan Baker, HCHS/DS; Greg Miller & Peter Albert, Retreat Healthcare; Michael Sabourin; Sandy Steingard, HCHS;

Chair: Bob Pierattini, FAHC/UVM

Staff: Beth Tanzman, Bill McMains, Cindy Thomas, Norma Wasko, VDH

Agenda:
Review of Draft RFP for "Clinical Design Services for Adult Mental Health Acute and Intensive Care Management System" and CRT Directors' Pilot Project Proposal

Update- Tom Simpatico -Electronic Medical Record (EMR)
The Steering Committee has looked at two electronic medical records systems and found the CRIS (Clinical Research Information System developed by Duke University) to be the best. It has capacity to link to existing (different) software systems already in place (to handle such things as admissions, transfers, billing, etc.). The next step is to see the CRIS in an applied setting. The Steering Committee on the Emergency Medical Record will make recommendations to Secretary LaWare on use of EMR, especially for VSH.

<u>Discussion of Bridge between EMR and Care Management System</u>
The information needs of a care management system will likely differ from the needs of any given clinical service provider. The CRIS electronic record system will have the potential to make key assessment information available for different applications such as nursing, patient preferences, etc.

The Work Group will need to identify the data elements necessary for operation of the care management system; then we will be able assess the utility of different IT systems. A key area for assessment is the ability to capture narrative information which is often critical for patient assessment and support, but it is often not well captured in EMR systems.

It was the sense of the group that the Steering Committee should see what has been done elsewhere to avoid reinventing the wheel as the EMR system develops.

Review of Care Management Request for Proposal – Beth Tanzman

Beth explained that the background for the development of the RFP is the solid work that has already been done by the Care Management Group (e.g., defining the criteria for moving patients to various levels of care within an integrated system). However, much work remains to create and implement the system. The level of work required to do this is beyond the capacity of the Work Group's available time and resources. It therefore seemed appropriate to secure a contractor to carry out the next phase of work to develop the care management system.

Scope of Proposed Work

The activities of the contractor would be to:

a) identify options for management structures for clinical care management systems;
b) create consistent, written program descriptions for the various levels of care;
c) create consistent, specific clinical admission, continued stay, and discharge criteria for each of the levels of care in the program descriptions;
d) develop uniform protocols to operationalize the various functions and activities in the care management system, based on the overall principles developed by the Care Management Work Group;
e) identify design options for quality improvement and utilization review for the Clinical Care Management System;
f) provide staffing support to the Care Management Work Group throughout the design and development process;
g) develop a final report detailing system design and program elements.

The deliverable would be a report, also clinical protocols, management models, etc. Work would proceed through calendar year 2007.

Review of CRT Pilot Proposal – Richard Lanza

The intent of this pilot is to develop the care management program from the ground up, and to test what works in partnership with other systems. It can best be thought about as a systems recovery initiative to move the entire CRT system out of the crisis mode. The underpinning or foundation concept is that the system would collectively share program development and we would do this work in a collaborative fashion rather than as independent entities each undertaking different activities.

One way to do this would be to implement programs in the quality improvement mode. Implementation could start with existing principles and protocols and the levels of change criteria; participating organizations could put these into play, collect data, share information and evaluate the results. A key idea is to use the modified LOCUS instrument (in collaboration with VSH) to describe people who are moving through the system. The levels of change criteria could be used to assess how well the system responds.

The pilot, because it proposes specific additional staff, would not require additional work by the agencies, just a different conversation. The principles & protocols would drive the

system (as opposed to a central care management body driving people through the system). The key point is that the pilot would build on key criteria that have been defined by the Care Management Work Group for moving people to various levels of care.

The following elements required to implement the pilot are already in place: the LOCUS instrument (Level of Client Utilization Scale) and the agreements among CRT & VSH to use it; and the work already done on Levels of Change Criteria.

The following new resources would be required: one masters level clinician for each crisis program and a laptop; one care management position to do the coordination work.

The proposed pilot process would be to evaluate & assess the data points as people are referred to crisis beds and leave them. The care manager would use case review and team meetings (already in place); the care system manager would facilitate the management process and enter data into the system.

Discussion:
The members of the group liked the concept. Bill McMains suggested that the pilot would permit using the PDSA, plan-do-study-act model. But the cost is high. The suggestion was made that perhaps the project could use an administrative assistant rather than a masters level clinician to collect the data.

The main difficulty in using the LOCUS is that different raters get different results. Training will be required in inter-rater reliability for the data points to be able to generate credible, usable data. It is time intensive to do this correctly.

The proposal is designed not to be presumptuous about boundaries but ultimately, we need an entity that works across the entire system. Why not do a pilot across a whole community system, involving residential, crisis bed and hospital levels of care? The community should include a hospital so it would be possible to test how the system moves people through several different levels of care. We could have an independent body review the results. The advantage of the pilot is that it will allow us to see what really happens during implementation.

What this proposal allows us to do is validate the reliability of the LOCUS. This is one, needed, component of the system. It does not address the problem of the bed that isn't there. The key is to have a position devoted to the care management function.
The question is how to staff and then analyze the data. We could probably use an administrative assistant to input the data. How many FTE's would be required? What about DMH providing staff to assist with QM analysis? The difficulty with this suggestion is that the Division is actively recruiting acute care staff and it may be awhile before these positions are filled.

A significant question is how applicable will the data be to inform the fail-safe network that was envisioned. We really need a map of the system before we do a pilot. The RFP would give us the map. We could then follow up with a field trial.

We need system process and outcome measures, such as lower readmission rates, decreased time it takes to reach a decision regarding placement, goodness of fit between clinical needs and resources. We would want a profile of high risk clients, and costs. By linking data to dollars per patient we could identify gaps, begin to get outcome measures for the system.

We are talking about two different areas and we need help with both. But if we do both we will need to scale back the scope and cost of proposals. What about sequencing the proposals? We could begin with RFP and follow up with the CRT project. Beth indicated that there is the possibility of funding Care Management RFP with FY07 budget dollars, and obtain the deliverables by December 07. It would be possible to begin the pilot in the fall of 07 using FY08 dollars.

Decision:
We need to do both the RFP and the pilot, and we should try to scale each to fit within the budget dollars that are available.

The Work Group recommended that the Division proceed with the Care Management RFP in combination with a one community scaled down pilot. The deliverables for the RFP should be due by December 2007, and the pilot should begin during the fall. The Care Management Group's role will be to facilitate the consultant's work by setting up meetings (especially with CRT staff to talk about the difficulties encountered at their point of entry to the system; these meetings will be useful to identify process and outcome measures of system effectiveness), and provide project oversight and review.

Next Steps:
Review by Futures Advisory Group

Addendum
The Futures Advisory Group reviewed the proposal for a pilot and the RFP at the January 29 meeting and provided feedback helpful for implementing both.